The State has in place a public process which complies with the requirements of Section 1902(a)(13)(A) of the Social Security Act.

Rule 14.6. Rate-Setting Criteria for Nursing Facilities

405 IAC 1-14.6-1 Policy; scope

Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-21-2

Affected: IC 12-13-7-3; IC 12-15; IC 24-4.6-1-101

Sec. 1. (a) This rule sets forth procedures for payment for services rendered to Medicaid recipients by duly certified nursing facilities (NF). All payments referred to within this rule are contingent upon the following:

(1) Proper and current certification.

(2) Compliance with applicable state and federal statutes and regulations.

(b) The procedures described in this rule set forth methods of reimbursement that promote quality of care, access, efficiency, economy, and consistency. These procedures recognize level and quality of care, access, establish effective accountability over Medicaid expenditures, provide for a regular review mechanism for rate changes, and, only to the extent the state is required to by state law, compensate providers for reasonable, allowable costs which must be incurred by efficiently and economically operated facilities. The system of payment outlined in this rule is a prospective system. Cost limitations are contained in this rule that establish parameters regarding the allowability of costs and define reasonable allowable costs.

(c) Retroactive payment or repayment will be required when an audit verifies an underpayment or overpayment due to intentional misrepresentation, billing or payment errors, or misstatement of historical financial or historical statistical data, or resident assessment data which caused a lower or higher rate than would have been allowed had the data been true and accurate. Upon discovery that a provider has received overpayment of a Medicaid claim from the office, the provider must complete the appropriate Medicaid billing adjustment form and reimburse the office for the amount of the overpayment, or the office shall make a retroactive payment adjustment, as appropriate.

405 IAC 1-14.6-2 Definitions

Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-21-2

Affected: IC 12-13-7-3; IC 12-15; IC 16-10-1

Sec. 2. (a) As used in this rule, "administrative component" means the portion of the Medicaid rate that shall reimburse providers for allowable administrative services and supplies, including prorated employee benefits based on salaries and wages. Administrative services and supplies include the following:

(1) Administrator and co-administrators, owners' compensation (including directors fees) for patient-related services.

(2) Services and supplies of a home office that are allowable and patient related and are appropriately allocated to the nursing facility.

(3) Office and clerical staff.

(4) Legal and accounting fees.

(5) Advertising.

(6) Travel.

(7) Telephone.

(8) License dues and subscriptions.

(9) Office supplies.

(10) Working capital interest.

(11) State gross receipts taxes.

(12) Utilization review costs.

(13) Liability insurance.

(14) Management and other consultant fees.

(15) Qualified Mental Retardation Professional (QMRP).

(b) As used in this rule, "allowable per patient day cost" means a ratio between allowable cost and patient days.

(c) As used in this rule, "annual financial report" refers to a presentation of financial data, including appropriate supplemental data, and accompanying notes, derived from accounting records and intended to communicate the provider's economic resources or obligations at a point in time, or changes therein for a period of time in compliance with the reporting requirements of this rule.

(d) As used in this rule, "average allowable cost of the median patient day" means the allowable per patient day cost (including any applicable inflation adjustment) of the median patient day from all providers when ranked in numerical order based on average allowable cost. The average allowable cost (including any applicable inflation adjustment) shall be computed on a statewide basis and shall be maintained by the office with revisions made four (4) times per year effective January 1, April 1, July 1, and October 1.

(e) As used in this rule, "average historical cost of property of the median bed" means the allowable patient-related property per bed for facilities that are not acquired through an operating lease arrangement, when ranked in numerical order based on the allowable patient-related historical property cost per bed that shall be updated each calendar quarter. Property shall be considered allowable if it satisfies the conditions of section 14(a) of this rule.

(f) As used in this rule, "calendar quarter" means a three (3) month period beginning January 1, April 1, July 1, or October 1.

(g) As used in this rule, "capital component" means the portion of the Medicaid rate that shall reimburse providers for the use of allowable capital-related items. Such capital-related items include the following:

(1) The fair rental value allowance.

(2) Property taxes.

(3) Property insurance.

(4) Repairs and maintenance.

(h) As used in this rule, "case mix index" (CMI) means a numerical value score that describes the relative resource use for each resident within the groups under the Resource Utilization Group (RUG-III) classification system prescribed by the office based on an assessment of each resident. The facility CMI shall be based on the resident CMI, calculated on a facility-average, time-weighted basis for the following:

(1) Medicaid residents.

(2) All residents.

This information shall be made available to the provider for purposes of tracking the facility's CMI.

(i) As used in this rule, "cost center" means a cost category delineated by cost reporting forms prescribed by the office.

(j) As used in this rule, "delinquent MDS resident assessment" means an assessment that is not electronically transmitted to the office or its contractor by the fifteenth day of the second month following the end of a calendar quarter, or an assessment that is greater than one-hundred thirteen (113) days old, as measured by the R2b date field on the MDS.

(k) As used in this rule, "desk audit" means a review of a written audit report and its supporting documents by a qualified auditor, together with the auditor's written findings and recommendations.

(l) As used in this rule, "direct care component" means the portion of the Medicaid rate that shall reimburse providers for allowable direct patient care services and supplies, including prorated employee benefits based on salaries and wages. Direct care services and supplies include all:

(1) nursing and nursing aide services;

(2) nurse consulting services;

(3) pharmacy consultants;

(4) medical director services;

(5) nurse aide training;

(6) medical supplies;

(7) oxygen;

(8) therapy services;

(9) and medical records costs.

(m) As used in this rule, "fair rental value allowance" means a methodology for reimbursing nursing facilities for the use of allowable facilities and equipment, based on establishing a rental valuation on a per bed basis of such facilities and equipment, and a rental rate.

(n) As used in this rule, "field audit" means a formal official verification and methodical examination and review, including the final written report of the examination of original books of accounts and resident assessment data and its supporting documentation by auditors.

(o) As used in this rule, "forms prescribed by the office" means cost reporting forms provided by the office or substitute forms that have received prior written approval by the office.

(p) As used in this rule, "general line personnel" means management personnel above the department head level who perform a policymaking or supervisory function impacting directly on the operation of the facility.

(q) As used in this rule, "generally accepted accounting principles" or "GAAP" means those accounting principles as established by the American Institute of Certified Public Accountants.

(r) As used in this rule, "inaccurate MDS resident assessment" means an assessment where one or more data items that are required to classify a resident pursuant to the RUG-III resident classification system is not supported according to the MDS supporting documentation guidelines as set forth in 405 IAC 1-15.

(s) As used in this rule, "incomplete MDS resident assessment" means an assessment that does not contain all data items that are required to classify a resident pursuant to the RUG-III resident classification system (e.g., MDS RUG fields that include blanks, out-of-range, or inconsistent responses), or an assessment that is not printed by the nursing facility provider upon request by the office or its contractor.

(t) As used in this rule, "indirect care component" means the portion of the Medicaid rate that shall reimburse providers for allowable indirect patient care services and supplies, including prorated employee benefits based on salaried and wages. Indirect care services and supplies include the following:

(1) Allowable dietary services and supplies.

(2) Raw food.

(3) Patient laundry services and supplies

(4) Patient housekeeping services and supplies.

(5) Plant operations services and supplies.

(6) Utilities.

(7) Social services.

(8) Activities supplies and services.

(9) Recreational supplies and services.

(u) As used in this rule, "Minimum data set (MDS) means a core set of screening and assessment elements, including common definitions and coding categories, that form the foundation of the comprehensive assessment for all residents of long term care facilities certified to participate in the Medicaid program. The items in the MDS standardize communication about resident problems, strengths, and conditions within facilities, between facilities, and between facilities and outside agencies. Version 2.0 (1/30/98) is the most current form to the minimum data set (MDS 2.0). The Indiana system will employ the MDS 2.0 or subsequent revisions as approved by the Health Care Financing Administration.

(v) As used in this rule, "medical and nonmedical supplies and equipment" include those items generally required to assure adequate medical care and personal hygiene of patients.

(w) As used in this rule, "normalized allowable cost" means total allowable direct patient care costs for each facility divided by that facility's average case mix index (CMI) for all residents.

(x) As used in this rule, "office" means the office of Medicaid policy and planning.

(y) As used in this rule, "ordinary patient-related costs" means costs of allowable services and supplies that are necessary in delivery of patient care by similar providers within the state.

(z) As used in this rule, "patient/recipient care" means those Medicaid program services delivered to a Medicaid enrolled recipient by a certified Medicaid provider.

(aa) As used in this rule, "reasonable allowable costs" means the price a prudent, cost conscious buyer would pay a willing seller for goods or services in an arm's-length transaction, not to exceed the limitations set out in this rule.

(bb) As used in this rule, "related party/organization" means that the provider is associated or affiliated with, or has the ability to control, or be controlled by, the organization furnishing the service, facilities, or supplies, whether or not such control is actually exercised.

(cc) As used in this rule, "RUG-III resident classification system" means the resource utilization group used to classify residents.

(dd) As used in this rule, "unit of service" means all patient care included in the established per

diem rate required for the care of an inpatient for one (1) day (twenty-four (24) hours).

(ee) As used in this rule, "untimely MDS resident assessment" means a significant change MDS assessment, as defined by HCFA's Resident Assessment Instrument (RAI) Manual, that is not completed within fourteen (14) days of determining that a nursing facility resident's condition has changed significantly; or a full MDS assessment that is not completed as required by 405 IAC 1-15-6(a) following the conclusion of all physical therapy, speech therapy, and occupational therapy.

405 IAC 1-14.6-3 Accounting records; retention schedule; audit trail; accrual basis; segregation of accounts by nature of business and by location

Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-21-2

Affected: IC 12-13-7-3; IC 12-15

Sec. 3. (a) Generally accepted accounting principles shall be followed in the preparation and presentation of all inancial reports and all reports detailing change of provider transactions unless otherwise prescribed by this rule.

(b) Each provider must maintain financial records for a period of three (3) years after the date of submission of financial reports to the office. The accrual basis of accounting shall be used in all data submitted to the office except for government operated providers that are otherwise required by law to use a cash system. The provider's accounting records must establish an audit trail from those records to the financial reports submitted to the office.

(c) In the event that a field audit indicates that the provider's records are inadequate to support data submitted to the office and the auditor is unable to complete the audit and issue an opinion, the provider shall be given, in writing, a list of the deficiencies and allowed sixty (60) days from the date of receipt of this notice to correct the deficiencies. In the event the deficiencies are not corrected within the sixty (60) day period, the office shall not grant any rate increase to the provider until the